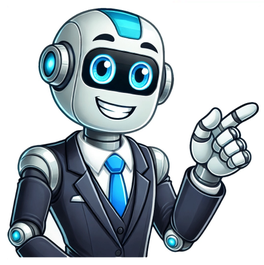
I'm not a robot



Dissociative Identity Disorder (DID) – formerly known as Multiple Personality Disorder – is a relatively common psychiatric disorder that may affect 1-3% of the general population. DID is characterized by a significant disruption of a unified sense of self and continuity of experience, exemplified by two or more personality/identity/self states. In some cultures, this disruption of a unified sense of self may be understood as an experience of possession that is not considered congruent with that culture's spiritual/religious practices. In addition, individuals with DID experience Dissociative Amnesia (DA): a disruption in memory for important personal information, as well as for current and past personal experience, that is inconsistent with ordinary memory problems. This significant disruption in a unified sense of self and memory can occur in a number of ways that include hard to explain disturbances and/or variability in: Behavior Thoughts Emotions Memory Perceptions Consciousness Bodily sensations or functioning These disruptions and alterations cannot be better explained by the effects of alcohol or drugs, or a medical or brain disorder, such as epileptic seizures. These symptoms must cause significant problems with functioning. Unlike portrayals in the media, the "fascinating", stereotyped external characteristics of DID self states, such as different names, voice tone, accents, wardrobe, hair-styles, handwriting, and more, are not essential for diagnosis and are secondary factors to the core phenomena of DID. The diagnostic criteria for DID mean that there are two or more relatively separate centers of information processing in the mind. Each information processing center in the mind is characterized by: A sense of personal identity A self-image A set of (state dependent) autobiographical memories A sense of ownership of personal experience Capacity to control/enact behavior These self states may shift, switch, or overlap in a number of ways that lead to the disruption in self and continuity of experience in DID. The individual's personality/identity/self states are NOT separate people. These are subjective states of the individual's mind. All of the DID states together make up the whole person and that person's total personality. Because of this, and unlike descriptions in the popular media, the individual with DID as a whole person is held responsible for behavior, even if experienced with amnesia or a sense of lack of control over one's actions. The Development of Dissociative Identity Disorder Individuals with DID report the highest rates of childhood trauma, particularly physical, sexual, and emotional abuse – generally beginning before the age of six – of patients with any psychiatric disorder. Because of this, DID can be conceptualized as a childhood onset, posttraumatic developmental disorder in which the traumatized child is unable to complete the normal developmental processes involved in consolidating a core sense of self. Together with disturbed caretaker-child attachment and parenting, repeated early trauma disrupts the development of normal processes involved in the elaboration and consolidation of a unified sense of self. Therefore, the child fails to integrate the different experiences of self that normally occur across different states and contexts. DID has been found in children, adolescents, and adults. Unfortunately, early trauma may be a risk factor for later trauma. DID individuals report very high rates of adult rape, intimate partner violence, and other forms of exploitation, such as being a victim of trafficking. DID is both a disorder and a form of resilience. Psychological compartmentalization of traumatic/overwhelming experiences allows for more normal development of the capacity for clear thinking, intellectual and creative abilities, the ability to understand reality, development of a sense of humor, the capability for attachment to others, and a capacity for insight – all important in the psychotherapy treatment of DID. Symptoms of Dissociative Identity Disorder (DID) The posttraumatic origins of DID mean that anywhere between 80 and 100% of individuals with DID who receive treatment also have symptoms of posttraumatic stress disorder (PTSD - see section on PTSD). Other disorders commonly associated with DID are depression or very rapid "mood swings" that frequently do not (or only very partially) respond to medications; substance abuse; and unexplained medical symptoms with repeated "negative" work ups, typically for apparent seizures or other neurological disorders. One of the most common symptoms of DID is hearing voices, most often within the mind. Because of this, many individuals with DID are unsuccessfully treated with medications for schizophrenia or other psychotic disorders (see section on psychotic disorders). Individuals with DID have very high rates of self-destructive and suicidal behavior and often have multiple, usually unproductive, hospitalizations for mood disorders, personality disorders, and/or psychotic diagnoses. The average individual with DID spends five to 12.5 years in mental health treatment until a correct diagnosis is made. Having suicidal or self-destructive thoughts, impulses, urges, plans or behavior require emergency treatment, including calling 911 or going to the nearest Emergency Department or Mental Health Urgent Care Clinic. A diagnosis of dissociative identity disorder should be suspected if you or your loved one: Receives numerous different psychiatric diagnoses, yet does not respond to many different types of treatments including multiple medications, types of psychotherapy, or neurostimulation treatments like electroconvulsive therapy (ECT) and transcranial magnetic stimulation (TMS). Unlike the stereotype of DID, symptoms of DID are usually subtle and hidden, and individuals with DID do not readily reveal their symptoms without careful examination by a mental health professional. You or your loved ones may notice the person is: Repeatedly very "moody" Highly changeable from time to time, and Has difficulty recalling important personal experiences. This can include a variety of current behaviors and parts of the life history, that are not related to use of substances or medications, or to brain injuries or diseases. These difficulties recalling important personal experiences can include: Significant gaps in memory for life history Experiencing "black outs" or "time loss": gaps in remembering current life history Lack of recall of complex, witnessed behaviors – even positive behaviors, such as doing well in a presentation at work Not remembering or difficulty remembering important events, such as graduations, birthdays, weddings, and vacations, that other family members recall well Recurring puzzling lack of memory for things that the person has purchased or created Inexplicable alterations in abilities and habits, such as forgetting that one can play a musical instrument, or changing suddenly from a smoker to a non-smoker, then back again Repeated unexplained travel or "getting lost" in familiar places Repeated rationalizations for being "forgetful" or "preoccupied" Other common symptoms of DID include: Hearing voices, particularly inside one's mind; these are often experienced as having their own sense of self, such as a child's voice, an angry voice, a caring and supportive voice, among others Seeing things that others do not see, such as people, faces, or visions, including seeing the "people" that one is hearing talking Out of body experiences, as if watching oneself from a distance outside, or even inside oneself, frequently accompanied by the feeling that one can observe, but not control what one is doing Feeling like you are disconnected from the world around you as if seeing through a fog; things seem unreal Experiencing repeated inexplicable, sudden intrusions of thoughts, feelings, urges, or actions that one does not control Experiencing repeated inexplicable, sudden deletion of thoughts, feelings, behavior that one does not control Feeling divided with different senses of self that seem relatively independent of one another, and often are in a conflict or a struggle Inexplicably feeling very different at different times with varying opinions, abilities, habits, and access to memory and learned information Treatment of Dissociative Identity Disorder DID is a treatable disorder once it is properly diagnosed. Clinicians who understand DID symptoms can diagnose DID in the clinical interview. There are also paper and pencil tests that can help clinicians diagnose DID and other dissociative disorders. Studies show that DID symptoms improve over time when treated using Phasic Trauma Treatment. Phasic Trauma Treatment Phasic trauma treatment is a psychotherapeutic treatment that has three phases: Safety and stability Work on traumatic memories Re-integration into life In DID treatment, working directly with the DID identities is crucial to diminish symptoms and to maximize the resilience found in most people with DID. The first phase, safety and stability, is the most important. During this phase, individuals learn how to stabilize symptoms of DID and PTSD, using a variety of psychotherapeutic techniques and sometimes adjunctive/add-on medications. It is critical for the individual with DID to develop safety from suicidal and self-destructive behaviors, substance abuse, eating disorders, high risk behaviors, unsafe people, and other dangerous behaviors and situations. This is because DID develops in a childhood environment of repeated lack of safety and unpredictable danger. Without development of safety, DID treatment will not progress. Not all individuals with DID wish to address his/her traumatic experiences in depth. However, if the individual with DID agrees, and has achieved safety and stability, Phase 2 is focused more on carefully and slowly recalling the life history – which is often experienced as PTSD flashbacks. Therefore, this phase also involves ongoing work on safety and additional stabilization of DID and PTSD symptoms. In Phase 3, the individual's DID and PTSD symptoms have usually substantially moderated, and the individual with DID may even experience subjective fusion of some or all self states, with complete merging of the characteristics of these subjective identities. This frees up energy for a focus on living better in the present. Adjunctive/Add-On Treatments for Dissociative Identity Disorder Hypnotherapy: Hypnotherapy can be helpful in stabilizing DID and PTSD symptoms. However, hypnotherapy can only be used if the therapist has received certification in using hypnosis and has specialized training in its use in DID and other posttraumatic disorders. Make sure to ask your provider about his/her credentials in using hypnosis. Medications: Medications are adjunctive (add-on) treatments in DID treatment and do not directly affect the basic symptoms of DID. In DID treatment, medications do not have a major direct effect on symptoms unless there are other specific disorders present. For example, there are medications that can substantially improve symptoms of PTSD, although some people cannot take these due to side effects. Medications for depression and mood symptoms usually have limited effects, but may provide some symptom relief as long as the patient and practitioner have carefully identified which symptoms will and will not be helped by medications. Medications for anxiety symptoms can be moderately helpful but must be monitored carefully, especially in individuals with a history of substance abuse. Individuals with DID often have a complex, chronic sleep disturbance with difficulty falling asleep, staying asleep, nightmares, and even complex behaviors that appear to emerge out of sleep. There are medications that can help PTSD nightmares and this may improve sleep, if the patient does not have problematic side effects. Sedating medications often are only partially helpful. Specific DID psychotherapy is often required to assist with fears and flashbacks related to bed, night, and sleep, and nighttime dissociative symptoms. Other Types of Psychotherapy that can Assist with DID Treatment Other forms of psychotherapy such as dialectical behavioral therapy (DBT) and cognitive behavioral therapy (CBT) that is focused on trauma-related cognitive distortions can be helpful as adjunctive/add-on to the phasic psychotherapy for DID. Eye-Movement Desensitization and Reprocessing Therapy (EMDR): Eye-movement Desensitization and Reprocessing Therapy (EMDR) is a treatment that has been found to improve PTSD symptoms, typically in people who have experienced specific adult traumas. EMDR can significantly worsen the symptoms of DID, especially if used before the DID patient is stabilized in treatment. EMDR can be an adjunctive/add-on treatment if the therapist has full training in EMDR and has specialized training in its use in DID and other complex posttraumatic disorders. Group Therapy: Group therapy can be helpful for the stabilization of individuals with DID if they are in a group dedicated to patients with this diagnosis, and the group is facilitated by practitioners that are knowledgeable about DID treatment. Individuals with DID usually do not do well in general therapy groups, even those that focus on PTSD and trauma, but are not designed for severely dissociative patients. In general, DID experts do NOT recommend the use of non-professionally facilitated support groups in the treatment of DID, including online support groups. Both in-person and online "support" groups ultimately may have a severely negative impact on the individual with DID and his/her treatment. Family Involvement: Family treatment, usually with the patient's spouse, or significant other can be helpful, for education and to help support both the patient and the family during an often long and difficult treatment. In particular, family members are educated to not directly interact with the patient's varying self states, but should regard their partner as a "whole human being," and not a group of separate "people." Specialized couple's therapy may be helpful if the therapist is knowledgeable about treatment of childhood trauma and its impact on adult relationships. Rehabilitation Therapies: Adjunctive/add-on rehabilitation therapies like art therapy and occupational therapy can be helpful if the therapist has training in the use of these modalities in the treatment of complex posttraumatic disorders like DID. To learn more about dissociative identity disorder, visit The Trauma Disorders Services section of our website and the International Society for the Study of Trauma and Dissociation's website. health centersmental health center Individuals with DID often also suffer from other mental illnesses, including posttraumatic stress disorder (PTSD), borderline and other personality disorders, and conversion disorder. Dissociative identity disorder (DID), formerly called multiple personality disorder (in previous diagnostic manuals, like the DSM-IV), is a mental illness that involves the sufferer experiencing at least two clear identities or personality states, also called alters, each of which has a fairly consistent way of viewing and relating to the world. Some individuals with DID have been found to have alternate personalities that have distinctly different ways of reacting, in terms of emotions, pulse, blood pressure, and even blood flow to the brain. Health care professionals used to call the disorder multiple personality disorder (MPD), and people often colloquially referred to it as split personality disorder. Statistics regarding this disorder indicate that the incidence of DID is about 1% of all adults (general population) in the United States, from 1%-20% of patients in psychiatric hospitals and is described as occurring in girls equally to boys and up to nine times more often in women compared to men. However, this female preponderance may be due to difficulty identifying the disorder in males. Disagreement among mental health professionals about how this illness appears clinically and controversy about whether DID even exists adds to the difficulty of estimating how often it occurs. Some professionals continue to be of the opinion that DID does not exist. The nature of this skepticism is sometimes due to questions about why many more individuals who have endured the stress of terrible abuse as young children do not develop the disorder, why more children are not diagnosed as having DID, and why some DID sufferers have no history of significant trauma. One explanation for what some believe to be these inconsistencies is that given the highly complex and unknown nature of the human brain and psyche, many of those whom one would expect to develop dissociative identity disorder are spared due to their resilience. Another concern about the diagnosis of DID involves having to rely on the traumatic memories of those who suffer from this disorder. That DID is significantly more often assessed in individuals in North America compared to the rest of the world, for the most part, leads some practitioners to believe that DID is a culture-based concoction rather than a true condition. As with many other mental health issues, symptoms of the same disorder in children look very different from symptoms in adults. Studies that verify the presence of DID using multiple resources add credibility to the diagnosis. Research on individuals with DID that have little to no media exposure to information on the illness lends further credibility to the reliability of the existence of this mental health condition. While there is no proven specific cause of DID, the prevailing psychological theory about how the condition usually develops is as a reaction to severe childhood trauma. Specifically, it is thought that one way that some individuals respond to being severely traumatized as a young child is to wall off altered states of consciousness, in other words to dissociate, those memories. When that reaction becomes extreme, DID may be the result. As with other mental disorders, having a family member with DID may be a risk factor, in that it indicates a potential vulnerability to developing the disorder but does not translate into the condition being literally hereditary. Signs and symptoms of dissociative identity disorder include lapses in memory (dissociation), particularly of significant life events, like birthdays, weddings, or birth of a child; experiencing blackouts in time, resulting in finding oneself in places but not recalling how one got there; being frequently accused of lying when they do not believe they are lying (for example, being told of things they did but do not remember, not related to the influence of any drug or medical condition); finding items in one's possession but not recalling how those things were acquired; encountering people with whom one is unfamiliar but who seem to know them sometimes by another identity; being called names that are completely unlike their own name or nickname; finding items they have clearly written but are in handwriting other than their own; hearing voices inside their head that are not their own; not recognizing themselves in the mirror; feeling unreal (derealization); feeling detached from oneself, like they are watching themselves move through life rather than living their own life (depersonalization); feeling like more than one person. What's Schizophrenia? Symptoms, Types, Causes, Treatment See Slideshow There is no specific definitive test, like a blood test, that can accurately assess that a person has dissociative identity disorder. Therefore, mental health practitioners like psychiatrists, psychoanalysts, or clinical psychologists conduct a mental health interview that gathers information, looking for the presence of the signs and symptoms previously described. Using structured interviews like the Structured Clinical Interview for Dissociative Disorders (SCID-D) is thought to be particularly helpful in distinguishing DID from other mental illnesses. The diagnostic criteria described in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) for dissociative identity disorder are as follows: The presence of two or more distinct identities or personality states (each with its own relatively persistent pattern of perceiving, relating to, and thinking about him or herself and the world) At least two of the identities or personality states repeatedly take control of the person's behavior. An inability to recall important personal information that is too severe to be explained by ordinary forgetfulness The illness is not the result of the direct physiological effects of a substance (for example, blackouts or other abnormal behavior during alcohol or other drug intoxication) or a general medical condition (for example, seizures). In children, imaginary playmates or other fantasy play do not cause the symptoms. Professionals usually gather information about the individual's childhood and ask questions to explore whether the symptoms that the client is suffering from are not better accounted for by another mental health condition, dissociative or otherwise. Other types of dissociative disorders include depersonalization/derealization disorder (feeling detached from themselves or surroundings), dissociative amnesia (memory problems associated with a traumatic experience), other dissociative disorder (episodes of dissociation that do not qualify for one of the specific dissociative disorders just described but the professional determining the diagnosis describes the reason why the criteria for a specific dissociative disorder is not met, as in when a person is in a trance), and unspecified dissociative disorder, formerly called dissociative disorder, not otherwise specified (DD,NOS), which is characterized by episodes of dissociation that do not qualify for one of the specific dissociative disorders just described). As part of the assessment, mental health professionals also usually ask about other mental conditions and ensure that the person has recently received a comprehensive physical examination and any appropriate medical tests so that any physical conditions that may mimic symptoms of DID are identified and addressed. Dissociation, a major symptom of DID, occurs in a number of other mental illnesses. For example, an individual with this disorder may seek to relieve overwhelming trauma-related memories by engaging in the self-mutilation and other forms of self-harm/self-injurious and self-destructive behaviors found in those with borderline personality disorder. Also, feelings and behaviors that may appear to be caused by dissociation, but are not, make it all the more difficult to distinguish DID from other conditions. Somatic symptom disorder, conversion disorder, and schizophrenia are just a few such disorders. Rape and other adult trauma victims are quite vulnerable to developing dissociative symptoms. The controversy about whether DID exists, as well as the overlap of symptoms it has with a number of other conditions, sometimes results in misdiagnosis. Symptoms of some other mental disorders may be mistaken for dissociation. The apparent impulsivity of bipolar disorder or wide mood swings associated with bipolar disorder, borderline personality disorder, or narcissistic personality disorder when triggered by minor slights are examples. People may also confuse the unstable self-image of borderline personality disorder with dissociation. Blackouts related to substance use disorders (formerly described as substance abuse or dependence) are other instances of an individual being unaware of his or her surroundings that mimic dissociation. DID often co-occurs with other emotional conditions, including posttraumatic stress disorder (PTSD), borderline personality disorder (BPD), and a number of other personality disorders, as well as conversion disorder. DID is sometimes feigned by individuals who may be seeking attention, as in Munchausen's syndrome. It has also been appropriately diagnosed as well as feigned in individuals involved in the criminal justice and civil or family court systems (for example, forensic cases). Adding to the diagnostic difficulty is that people like pedophiles and other sex offenders, as well as people with antisocial personality disorder, may legally stand to gain from having DID. While some of those individuals may feign the diagnosis in an effort to benefit legally, others genuinely suffer from significant dissociative symptoms, as well as full-blown DID. In cases where there may be an ulterior motive for being diagnosed with DID, studies show that using a screening test or structured interview may be the best way to determine if the person truly suffers from this condition. Psychotherapy is generally considered the main component of treatment for dissociative identity disorder. In treating individuals with DID, therapists usually use individual, family, and/or group psychotherapy to help clients improve their relationships with others and to experience feelings they have not felt comfortable being in touch with or openly expressing in the past. It is carefully paced in order to prevent the person with DID from becoming overwhelmed by anxiety, risking a figurative repetition of their traumatic past being inflicted by those very strong emotions. Dialectical behavior therapy is a form of cognitive behavior therapy that emphasizes mindfulness and works on helping the DID sufferer soothe him- or herself by decreasing negative responses to stressors. Mental health professionals also often guide clients in finding a way to have each aspect of them coexist, and work together, as well as developing crisis-prevention techniques and finding ways of coping with memory lapses that occur during times of dissociation. The goal of achieving a more peaceful coexistence of the person's multiple personalities is quite different from the reintegration of all those aspects into just one identity state. While reintegration used to be the goal of psychotherapy, it has frequently been found to leave individuals with DID feeling as if the goal of the practitioner is to get rid of, or "kill," parts of them. Hypnosis sometimes helps increase the information that the person with DID has about their symptoms/identity states, thereby increasing the control they have over those states when they change from one personality state to another. This occurs by enhancing the communication that each aspect of the person's identity has with the others. In this age of insurance companies regulating the health care that most Americans receive, having time-limited, multiple periods of psychotherapy rather than intensive long-term care provides what may be another effective treatment option for helping people who are living with DID. Physicians increasingly use eye movement desensitization and reprocessing (EMDR), a type of treatment that integrates traumatic memories with the patient's own resources, in the treatment of people with dissociative identity disorder. It results in enhanced information processing and healing. Medications are often used to address the many other mental health conditions that individuals with DID tend to have, like depression, severe anxiety, anger, and impulse-control problems. However, particular caution is appropriate when treating people with DID with medications because any effects they may experience, good or bad, may cause the sufferer of DID to feel like they are being controlled, and therefore traumatized yet again. As DID is often associated with episodes of severe depression, electroconvulsive therapy (ECT) can be a viable treatment when the combination of psychotherapy and medication does not result in adequate relief of symptoms. As with other mental health conditions, the prognosis for people with DID becomes much less optimistic if not appropriately treated. Individuals with a history of being sexually abused, including those who go on to develop dissociative identity disorder, are vulnerable to abusing alcohol or other substances as a negative way of coping with their victimization. People with DID are also at risk for attempting suicide more than once. Violent behavior has a high level of association with dissociation as well. Other debilitating outcomes of DID, like that of other severe chronic mental illnesses, include inability to obtain and maintain employment, poor relationships with others, and therefore overall lower productivity and quality of life. Research indicates that people with dissociative identity disorder have their best opportunity for living a well-adjusted life if they receive comprehensive treatment for their multiple symptoms. However, differences in how practitioners diagnose and treat this illness make it difficult to quantify or predict outcomes. Given that the origin of dissociative identity disorder in the majority of individuals remains related to exposure to traumatic events, prevention for this disorder primarily involves minimizing the exposure to traumatic events, as well as helping survivors of trauma come to terms with what they have been through in a healthy way. By clicking "Submit," I agree to the MedicineNet Terms and Conditions and Privacy Policy. I also agree to receive emails from MedicineNet and I understand that I may opt out of MedicineNet subscriptions at any time. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR); 2000, Washington, D.C. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, Virginia: American Psychiatric Association, 2013. Applegate, M. Multiphasic short-term therapy for dissociative identity disorder. Journal of the American Psychiatric Nurses Association; 1997, 3(1): 1-9. Becker-Blease, K., Freyd, J. Dissociation and memory for perpetration among convicted sex offenders. Journal of Trauma and Dissociation; 2007, 8(2): 69-80. Bernstein, Carlson E.M., Putnam, F.W. Development, reliability and validity of a dissociation scale. Journal of Nervous and Mental Disease 1986; 174: 727-735. Brown, R.J., Schrag, A., Trimble, M.R. Dissociation, childhood interpersonal trauma and family functioning in patients with somatization disorder. American Journal of Psychiatry; May 2005, 162: 899-905. Carrion, V.G., Steiner, H. Trauma and dissociation in delinquent adolescents. Journal of the American Academy of Child and Adolescent Psychiatry; March 2000, 39(3): 353-359. DeBattista, C., Solvason, H.B., Spiegel, D. ECT in dissociative identity disorder and comorbid depression. Journal of Electroconvulsive Therapy; December 1998, 14(4): 275-279. Dell, P.F. Axis II pathology in outpatients with dissociative identity disorder. The Journal of Nervous and Mental Disease; June 1998, 186(6): 352-356. Dorahy, M.J., B.L. Brand, V. Sar, et al. "Dissociative identity disorder: An empirical overview." Australian New Zealand Journal of Psychiatry 48.5 May 2014: 402-417. Escobar, J. Transcultural aspects of dissociative and somatoform disorders. Psychiatric Times; April 15, 2004, 21(5). Fine, C.G. Treatment stabilization and crisis prevention. Pacing the therapy of the multiple personality disorder patient. Psychiatric Clinics of North America; September 1991, 14(3): 661-675. Foote, B., Smolin, Y., Neft, D., Lipschitz, D. Dissociative disorders and suicidality in psychiatric outpatients. The Journal of Nervous and Mental Disease; January 2008, 196(1): 29-36. Friedrich, W.N., Gerber, P.N., Koplin, B., Davis, M., Giese, J., Mykelbust, C., Franckowiak, D. Multimodal assessment of dissociation in adolescents: Inpatients and juvenile sex offenders. Sexual Abuse: A Journal of Research and Treatment; 2001, 13(3): 167-177. Griffin, M.G., Resick, P.A., Mechanic, M.B. Objective assessment of peritraumatic dissociation: psychophysiological indicators. American Journal of Psychiatry; 1997, 154: 1081-1088. International Society for the Study of Trauma and Dissociation (2011): Guidelines for Treating Dissociative Identity Disorder in Adults, Third Revision. Journal of Trauma & Dissociation 12.2: 115-187. Klanecky, A.K., Harrington, J., McChargue, D.E. Child sexual abuse, dissociation and alcohol: implications of chemical dissociation via blackouts among college women. American Journal of Drug and Alcohol Abuse; 2008, 34(3): 277-284. Lewis, D.O., Yeager, C.A., Swica, Y., Pincus, J.H., Lewis, M. Objective documentation of child abuse and dissociation in 12 murderers with dissociative identity disorder. American Journal of Psychiatry; June 1999, 156(6): 976. McMinn, M.R., Wade, N.G. Beliefs about the prevalence of dissociative identity disorder, sexual abuse, and ritual abuse among religious and nonreligious therapists. Professional Psychology: Research and Practice; June 1995, 26(3): 257-261. Middleton, W., and J. Butler. "Dissociative Identity Disorder: An Australian Series." Australian New Zealand Journal of Psychiatry 32.6 Dec. 1998: 794-804. Moskowitz, A. Dissociation and violence: a review of the literature. Trauma, Violence and Abuse; 2004, 5(1): 21-46. Peterson, G. "Assessment and treatment tools for dissociative disorders." Clinical Lecture Series, UNC-CH School of Social Work. November 2010. Piper, A., Merskey, H. The persistence of folly: a critical examination of dissociative identity disorder: Part I. The excesses of an improbable concept. Canadian Journal of Psychiatry; September 2004, 49(9): 592-600. Ramsland, K., Kuter, R. Multiple personalities: crime and defense. Turner Broadcasting System; 2008. Ross, C.A., Keyes, B.B., Yan, H., Wang, Z., Zou, Z., Xu, Y., Chen, J., Zhang, H., Xiao, Z. A cross-cultural test of the trauma model of dissociation. Journal of Trauma Dissociation; 2008, 9(1): 35-49. Sar, V., Akyuz, G., Kundakc, T., Kazaltan, E., Dogan, O. Childhood trauma, dissociation and psychiatric comorbidity in patients with conversion disorder. American Journal of Psychiatry; December 2004, 161: 2271-2276. Sar, V., Kundakci, T., Kiziltan, E., Yargic, I., Tutkun, H., Bakim, B., Bozkurt, O., Ozpulat, T., Keser, V., Ozdemir, O. The axis I dissociative disorder comorbidity of borderline personality disorder among psychiatric outpatients. Journal of Trauma and Dissociation; 2003, 4(1): 119-136. Simone Reinders, A.A.T., Nijenhuis, E.R.S., Quaka, J., Korfa, J., Haaksmab, J., Paans, A.M.J., Willemsen, A.T.M., den Boer, J.A. Psychobiological characteristics of dissociative identity disorder: a symptom provocation study. Biological Psychiatry; October 2006, 60(7): 730-740. Spiegel, D. Recognizing traumatic dissociation. American Journal of Psychiatry; April 2006, 163: 566-568. Spitzer, C., Klauer, T., Grabe, H.J., Lucht, M., Stieglitz, R.D., Schneider, W., Freyberger, H.J. Gender differences in dissociation: a dimensional approach. Psychopathology; 2003, 36(2). Twombly, J.H. "Incorporating EMDR and EMDR Adaptations into the Treatment of Clients with Dissociative Identity Disorder." Journal of Trauma and Dissociation 1.2 (2000): 61-81. van der Kolk, B.A., and O. van der Hart. "Pierre Janet and the Breakdown of Adaptation in Psychological Trauma." American Journal of Psychiatry 146.12 Dec. 1989: 1530-1540. Welburn, K.R., Fraser, G.A., Jordan, S.A., Cameron, C., Webb, L.M., Raine, D. Discriminating dissociative identity disorder from schizophrenia and feigned dissociation on psychological tests and structured interview. Journal of Trauma and Dissociation; 2003, 4(2): 109-130. The symptoms of DID include:Having at least two identities (personality states). These affect your behavior, memory, self-perception and ways of thinking.Amnesia or gaps in memory regarding daily activities, personal information and traumatic events.Different identities affect your ability to function in social situations or at work, home or school.Other mental health symptoms that can (but not always) be found along with DID include:Anxiety.Delusions.Depression.Self-harm.Substance use disorder.Thoughts about suicide (suicidal ideation).What does a person with DID feel like?If you have DID, you might feel or experience the following:Detached from reality, your emotions and your sense of self.Confused by what others may tell you about your behavior.Frustrated about gaps in your memory.Stressed about not being in control.Like a bystander, watching yourself from the outside.It doesn't feel like you're "you" with DID. This can look and feel different for each person who experiences it. If something doesn't feel right or your experiences and memories aren't lining up, reach out to a healthcare provider for an evaluation.Can someone have DID without knowing?Yes, it's possible that someone can have DID without knowing. While some people are aware of their identities, many people don't know when a new identity takes over. When a new identity steps in, you may not remember some events because another personality experienced them. This causes gaps in memory, called amnesia.What causes dissociative identity disorder?DID causes may include:Stressful experiences.Trauma.Abuse.These events typically happen during childhood. DID is a way for you to distance or detach yourself from the trauma.DID symptoms may trigger (happen suddenly) after:Removing yourself from a stressful or traumatic environment (like moving homes).Close relatives or your children reaching the age at which you experienced trauma.A recent traumatic or stressful experience (like a vehicle accident).An abuser passing away or experiencing a life-threatening illness.What are the risk factors for dissociative identity disorder?You may be more at risk of developing DID if you experienced:Physical or sexual abuse.Neglect.Multiple medical procedures during childhood.War or terrorism.What are the complications of dissociative identity disorder?You're at an increased risk of suicide with DID. More than 70% of people diagnosed with DID attempt suicide or practice self-injury behaviors.If you're thinking about hurting yourself, call or text 988, the Suicide & Crisis Lifeline (U.S.). You don't have to be in a crisis to dial 988. Someone is available to talk, no matter your situation, so you can feel better in your time of need. Reviewed by Psychology Today Staff Dissociative identity disorder, formerly referred to as multiple personality disorder, is characterized by a person's identity fragmenting into two or more distinct personality states. People with this condition are often victims of severe abuse. Dissociative identity disorder (DID) is a rare condition in which two or more distinct identities, or personality states, are present in—and alternately take control of—an individual. Some people describe this as an experience of possession. The person also experiences memory loss that is too extensive to be explained by ordinary forgetfulness. DID was called multiple personality disorder up until 1994 when the name was changed to reflect a better understanding of the condition—namely, that it is characterized by fragmentation or splintering of identity, rather than by proliferation or growth of separate personalities. The symptoms of DID cannot be explained away as the direct psychological effects of a substance or of a general medical condition. DID reflects a failure to integrate various aspects of identity, memory, and consciousness into a single multidimensional self. Usually, a primary identity carries the individual's given name and is passive, dependent, guilty, and depressed. When in control, each personality state, or alter, may be experienced as if it has a distinct history, self-image, and identity. The alters' characteristics—including name, reported age and gender, vocabulary, general knowledge, and predominant mood—contrast with those of the primary identity. Certain circumstances or stressors can cause a particular alter to emerge. The various identities may deny knowledge of one another, be critical of one another, or appear to be in open conflict. article continues after advertisement According to the DSM-5, the following criteria must be met for an individual to be diagnosed with dissociative identity disorder: The individual experiences two or more distinct identities or personality states (each with its own enduring pattern of perceiving, relating to, and thinking about the environment and self). Some cultures describe this as an experience of possession. The disruption in identity involves a change in sense of self, sense of agency, and changes in behavior, consciousness, memory, perception, cognition, and motor function. Frequent gaps are found in the individual's memories of personal history, including people, places, and events, for both the distant and recent past. These recurrent gaps are not consistent with ordinary forgetting. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. Particular identities may emerge in specific circumstances. Transitions from one identity to another are often triggered by emotional stress. In the possession-form of dissociative identity disorder, alternate identities are visibly obvious to people around the individual. In non-possession-form cases, most individuals do not overtly display their change in identity for long periods of time. People with DID may describe feeling that they have suddenly become depersonalized observers of their own speech and actions. They might report hearing voices (a child's voice or the voice of a spiritual power), and in some cases, the voices accompany multiple streams of thought that the individual has no control over. The individual might also experience sudden impulses or strong emotions that they don't feel control or a sense of ownership over. People may also report that their bodies suddenly feel different (like that of a small child or someone huge and muscular) or that they experience a sudden change in attitudes or personal preferences before shifting back. Sometimes people with DID experience dissociative fugue in which they discover, for example, that they have traveled, but have no recollection of the experience. They vary in their awareness of their amnesia, and it is common for people with DID to minimize their amnestic symptoms, even when the lapses in memory are obvious and distressing to others. Are dissociative states seen differently in other cultures? In many parts of the world, possession states are a normal part of cultural or spiritual practice. Possession-like identities often manifest as behaviors under the control of a spirit or other supernatural being. Possession states become a disorder only when they are unwanted, cause distress or impairment, and are not accepted as part of cultural or religious practice. Are suicidal thoughts common in dissociative identity disorder? According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, more than 70 percent of people with DID have attempted suicide at least once, and self-injurious behavior is common among this group. Treatment is crucial to improving quality of life and preventing suicide attempts for those with DID. Why some people develop dissociative identity disorder is not entirely understood, but they frequently report having experienced severe physical and sexual abuse during childhood. The disorder may first manifest at any age. Individuals with DID may have post-traumatic symptoms (nightmares, flashbacks, or startle responses) or post-traumatic stress disorder. Several studies suggest that DID is more common among close biological relatives of persons who also have the disorder than in the general population. Once a rarely reported disorder, the diagnosis has grown more common—and controversial. Some experts contend that because DID patients are highly suggestible, their symptoms are at least partly iatrogenic—that is, prompted by their therapists' probing. Brain imaging studies, however, have corroborated identity transitions. What other dissociative disorders are there? There are other dissociative disorders, all of which concern an individual's disconnection with reality. The person who suffers dissociative amnesia, for example, has difficulty remembering who they are, where they live, and other important personal information. And the person who suffers depersonalized or derealization disorder is detached from their actions. The primary treatment for dissociative identity disorder is long-term psychotherapy with the goal of deconstructing the different personalities and integrating them into one. Other treatments include cognitive and creative therapies. Although there are no medications that specifically treat this disorder, antidepressants, anti-anxiety drugs, or tranquilizers may be prescribed to help control the psychological symptoms associated with it. With proper treatment, many people who are impaired by DID experience improvement in their ability to function in their work and personal lives. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. National Institute of Mental Health Find a Dissociative Disorders (DID) Therapist Get the help you need from a therapist near you–a FREE service from Psychology Today. Atlanta, GA Austin, TX Baltimore, MD Boston, MA Brooklyn, NY Charlotte, NC Chicago, IL Columbus, OH Dallas, TX Denver, CO Detroit, MI Houston, TX Indianapolis, IN Jacksonville, FL Las Vegas, NV Los Angeles, CA Louisville, KY Memphis, TN Miami, FL Milwaukee, WI Minneapolis, MN Nashville, TN New York, NY Oakland, CA Omaha, NE Philadelphia, PA Phoenix, AZ Pittsburgh, PA Portland, OR Raleigh, NC Sacramento, CA Saint Louis, MO San Antonio, TX San Diego, CA San Francisco, CA San Jose, CA Seattle, WA Tucson, AZ Washington, DC Dissociative identity disorder comes with a lot of stigma and misunderstanding. We're here to bust some common myths.Share on PinterestEschCollection/Getty ImagesDissociative identity disorder (DID), previously known as multiple personality disorder, is a dissociative disorder. Many people with DID have a history of severe childhood abuse, which may have caused them to dissociate from their bodies to cope with overwhelming trauma.Symptoms of DID include a sense of feeling detached from one's sense of self and the presence of at least two other distinct personalities. Many people with DID experience memory gaps when different personalities take over.DID is one of the most misunderstood psychiatric disorders. It's important to address misconceptions with solid research to spread understanding and reduce the stigma around this disorder.Many people believe that DID isn't an actual condition or that it was a medical "fad." But DID has been reported for hundreds of years and makes a strong appearance in medical literature.Research published in 2014 confirms that dissociative identity disorder is a complex but valid condition that can be proven across many markers. Studies show that DID is linked to diverse brain regions and cognitive functions.The symptoms of DID can be easily distinguished from other conditions. The disorder is commonly associated with severe childhood relational trauma.Due to a spike in diagnoses during the 1980s and 1990s and then a decline, DID was called a medical fad. Some believe it was popular to diagnose people with this disorder at one point and that it simply fell out of style.But researchers note that DID cases have been described in medical literature for hundreds of years.In addition, researchers say there were 1,339 research papers about DID between 2000-2014. This suggests an ongoing professional interest in the disorder.Other factors dispelling this myth include:People with DID are consistently identified in inpatient, outpatient, and community samples worldwide.People with DID can be reliably diagnosed through structured/semi-structured interviews and in clinical practice.People with DID often benefit from psychotherapy that addresses trauma and dissociation.DID is easily differentiated from other psychiatric disorders.It's a general misconception — even in some psychology textbooks — that DID is rare. Prevalence rates in the general population and psychiatric settings suggest otherwise.In fact, DID is more common than schizophrenia.Research shows that DID is present in about 1.1% to 1.5% of community samples. In comparison, schizophrenia is estimated to occur in about 0.25% to 0.64% of adults.In a sample of 658 people from New York, 1.5% met the diagnostic criteria for DID. Similarly, in a study of 628 community women in Turkey, 1.1% had DID.In addition, studies looking at populations with exceptionally high exposure to trauma or cultural oppression show the highest rates of DID. For instance, 6% of repeated admissions in a highly traumatized U.S. inner-city sample were diagnosed with DID.Despite common belief, DID and schizophrenia are different disorders.A persistent myth about schizophrenia is that people with the condition have a "split personality" — the idea that the self is split into various identities.While recent mental health campaigns have aimed to educate people on the difference, the myth still lingers.Another contributor to this myth is that the symptoms of DID often overlap with the positive symptoms of schizophrenia, such as distorted perceptions of reality. But it's much less common for people with DID to share the negative symptoms of schizophrenia, such as social withdrawal or lack of pleasure.Another important distinction is that people with schizophrenia are less likely to experience dissociative symptoms, such as memory and identity loss. Schizophrenia is also a genetic illness that tends to run in families, and the disorder can result in a gradual decrease in functioning if left untreated. DID is not hereditary but is most often caused by trauma.Some people believe DID is a personality disorder, but this is not the case. DID is identified in the DSM-5 as a dissociative disorder.There are a few reasons people might think DID is a personality disorder. The previous name, "multiple personality disorder" (changed to DID in 1994), still sticks with some people and may cause confusion.While 2014 research shows that the two disorders overlap in symptoms (as many conditions do), they also have distinct features that set them apart. Dissociative disorders may involve memory gaps and a sense of detachment from oneself and the world. Personality disorders are marked by a consistent pattern of traits that interfere with a person's stable life.Research has not convincingly shown a link between DID and increased violence.Horror movies that feature characters with DID have contributed to this myth and may even be responsible for it. According to 2009 research, DID is a controversial diagnosis because of fear that criminals would not be punished if they claimed another personality committed the crime.But there is no association between DID and increased crime.A 2017 study found that among 173 people in treatment for dissociative identity disorder, their involvement with the criminal justice system was low. Researchers found that only 0.6% had been incarcerated within the past 6 months. In addition, no convictions or probations in the prior 6 months had been reported. Finally, they found that no DID symptoms reliably predicted criminal behavior.The myth that people with DID are dangerous leads to further stigmatizing those with this disorder.DID is a highly misunderstood psychiatric disorder. Tackling pervasive myths can help unravel the stigma that many people with DID experience.For more information about DID or help to find treatment, you can visit the International Society for the Study of Trauma and Dissociation (ISSTD) website.For further support, you can call The National Alliance on Mental Illness (NAMI) HelpLine at 1-800-950-6264 or email at info@nami.org. SymptomsCausesTreatmentWhen to see a doctorTakeawayDissociative identity disorder, previously known as multiple personality disorder, is a type of dissociative disorder. Along with dissociative amnesia and depersonalization-derealization disorder, it's one of the three major dissociative disorders.Dissociative disorders can be found in people of all ages, races, ethnicities, and backgrounds. The National Alliance on Mental Illness (NAMI) estimates that about 2 percent of people experience dissociative disorders.The most recognizable symptom of dissociative identity disorder (DID) is a person's identity being involuntarily split between at least two distinct identities (personality states). Other symptoms might include:Dissociative amnesia. This is a type of memory loss — beyond forgetfulness — that's not associated with a medical condition.Dissociative fugue. A dissociative fugue is an episode of amnesia that involves not having memory of certain personal information. It may include wandering off or a detachment from emotion.Blurred identity. This occurs when you feel like there are two or more people talking or living in your head. You might even feel like you're possessed by one of several other identities.It's important to note that according to the Diagnostic and Statistical Manual of Mental Disorders, many cultures around the globe include possession as part of a normal spiritual ritual or practice. This isn't considered a dissociative disorder.If you believe someone you know has DID, you may get the impression that you're communicating with not one, but several different people, as the person switches between personalities.Often, each identity will have their own name and characteristics. They'll each commonly have an unrelated detailed background with obvious differences in age, gender, voice, and mannerisms. Some might even have individual physical characteristics such as a limp or poor vision that requires glasses.There are often differences in each identity's awareness and relationship — or lack thereof — to the other identities.Dissociative identity disorder — along with other dissociative disorders — usually develop as a way to deal with some type of trauma they've experienced.According to the American Psychiatric Association, 90 percent of people with dissociative identity disorder in the United States, Canada, and Europe have experienced childhood neglect or abuse.The primary treatment for DID is psychotherapy. Also known as talk therapy or psychosocial therapy, psychotherapy is focused on talking with a mental health professional about your mental health.The goal of psychotherapy is to learn how to cope with your disorder and to understand the cause of it.Hypnosis is also considered by some to be a useful tool for DID treatment.Medication is sometimes used in the treatment of DID, as well. Although there are no medications specifically recommended for the treatment of dissociative disorders, your doctor might use them for associated mental health symptoms.Some commonly used medications are:anti-anxiety medicationsantipsychotic drugsantidepressantsIf you can identify with any of the following, you should make an appointment to see your doctor:You are aware — or others observe — that you involuntarily and unwillingly have two or more personalities or identities that have a distinctly different way of relating to you and the world around you.You experience beyond ordinary forgetfulness, like extensive gaps in your memory for important personal information, skills, and events.Your symptoms aren't caused by a medical condition or from the use of alcohol or drugs.Your symptoms are causing you problems or stress in important areas such as your personal life and at work.If you identify with the symptoms of dissociative identity disorder, you should make an appointment to see your doctor.If your friend or a loved one is displaying the common symptoms, you should encourage them to seek help. You can also contact the NAMI HelpLine at 1-800-950-6264 or email info@nami.org for support. Dissociative Identity Disorder (DID) (also previously known as multiple personality disorder), is a mental disorder characterized by at least two distinct and relatively enduring personality states. Individuals with DID may report they have suddenly become depersonalized observers of their "own" speech and actions, and feel powerless to stop it. They may also report perceptions of voices (e.g. - a child's voice, crying, the voice of a spiritual being). DID remains a controversial diagnosis despite its inclusion in the DSM-5. It is highly comorbid with other psychiatric disorders including psychotic disorders, personality disorders, substance use disorders, and posttraumatic stress disorder (PTSD).[1] Disruption of identity characterized by 2 or more distinct personality states, which may be described in some cultures as an experience of possession. The disruption in identity involves marked discontinuity in sense of self and sense of agency, accompanied by related alterations in affect, behaviour, consciousness, memory, perception, cognition, and/or sensory-motor functioning. These signs and symptoms may be observed by others or reported by the individual. Recurrent gaps in the recall of everyday events, important personal information, and/or traumatic events that are inconsistent with ordinary forgetting. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. The disturbance is not a normal part of a broadly accepted cultural or religious practice. The symptoms are not attributable to the physiological effects of a substance (e.g. - blackouts or chaotic behaviour during alcohol intoxication) or another medical condition (e.g. - complex partial seizures). Name Rater Description Download Dissociative Experiences Scale (DES) Patient The scale is a 28-item self-report questionnaire measuring dissociation in normal and clinical populations. The mean of all item scores ranges from 0 to 100 and is called the DES score. There are two versions of the DES, there is the original DES, and the second version, the DES-II.[2] See also the DES Taxon Calculator to help differentiate between pathological and normal dissociation. DES Download Dissociative identity disorder is associated with overwhelming experiences, traumatic events, and/or abuse occurring in childhood. The full disorder may first manifest at al most any age (from earliest childhood to late life). Prevalence of childhood abuse and neglect is about 90% in Western countries. A trauma-informed phase-based psychotherapy approach is recommended by international guidelines, which focuses on:[3][4] See also: Psychiatry Clinical Practice Guidelines (CPGs)